Bellaire Family Eye Care
...for a lifetime of clear and healthy vision
NeuroSensory Center of Bellaire

# RELEASE OF INFORMATION

Under the current HIPAA laws, patients have the right to restrict the uses and disclosure of medical information. By signing this Release of Information Form, you are giving permission to release information to the sources listed below.

I hereby authorize the use or disclosure of _____'s (Patient name) (Date of Birth) _____ protected health information and release of records with Bellaire Family Eye Care and the Vision Learning Center to discuss diagnosis, treatment and progress notes between the professionals listed below.

Name: _____ Title: _____

Phone: _____ Fax: _____

Street Address: _____

City _____ State: _____ Zip: _____

Name: _____ Title: _____

Phone: _____ Fax: _____

Street Address: _____

City _____ State: _____ Zip: _____

Name: _____ Title: _____

Phone: _____ Fax: _____

Street Address: _____

City _____ State: _____ Zip: _____

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